STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968090	**05/24/2017**
NAME OF PROVIDER OR SUPPLIER **PARK PLACE ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8200 SW 43RD TERRACE MIAMI, FL 33155**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Standard Biennial Survey was conducted on , 2017. Park Place Assisted Living Inc. (License #12042) had deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview the facility failed to have a face-to-face physical examination after a significant change for 3 out of 7 sampled residents (Resident # 3, # 5 and # 6) who were admitted to hospice services and had a ,

Findings included:

On from 7:45 am to 3:30 pm Resident #3 was observed in bed. Lunch observations on at 12:15 pm revealed Staff C fed the resident in bed.

Record review of Resident #3's file revealed the resident had been receiving hospice services since . The last health assessment was completed on before the resident was placed under hospice services. The assessment stated that the resident required assistance with all her activities of daily living (ADLs), assistance with self-administration of medications, and that the resident did not have , . Record review also revealed that at the time of the survey the resident had a , in the sacrum.

The administrator stated on at 1:10 pm that Resident #3 has a , on the sacrum, requires total assistance with her ADLs and medication administration.

Record review of Resident #5's file revealed that the resident has been receiving hospice services since . Also revealed that the last health assessment was completed on and stated that she required assistance was her ADLs and medication administration.

On at 12:00 pm Resident #5 was observed being fed by Staff C. The administrator stated at 2:23 pm that Resident #5 is able to assist with ambulation and transferring, but requires total assistance with the rest of her ADLs.

On at 2:30 pm observed Resident #5 ambulating to her the assistance of the 2 caregivers.

Record review of Resident #6's file revealed that the resident has been receiving hospice services since

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. Also revealed that the last health assessment was completed on , previously to the resident being admitted to hospice and stated that she was independent with eating and required assistance with all her ADLs and assistance with self-administration of medications and eats a regular diet.

On during the survey Resident #6 was in bed mostly asleep and woke up only to feed herself and to be interviewed.

The administrator stated on at 1:35 pm that Resident #6 was able to feed herself but required total assistance with the ADLs and medication administration and that she eats puree diet.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview the facility failed to honor the residents rights by using side rails as a for 1 out of 7 sampled residents (Resident # 1).

Findings included:

During the tour of the facility on at 7:52 am, Resident #1 was observed sleeping in bed with a half bed rail up.

Record review of Resident #1 files revealed the consent for half bed rail had been signed by his wife on . The facility failed to have an order for the use of side rail.

On at 10:20 am the administrator stated, "I do not have a prescription for half side rail use because the doctor has not been here yet. I am afraid to remove the side rails because he can out of bed. He is not able to get out of bed with the side rails up and he cannot remove them."

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview the facility failed to follow the steps when assisting residents with self-administration of medications for 2 out of 7 sampled residents (# 2 and 4).

Findings included:

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During assistance with self-administration of medication on at 8:42 am observed Staff C assisting Resident # 2 with self-administration of medications; Staff C came with a little container with the medications pills that had already been punched out of the cards. Staff C failed to say the name of the medications to the resident, she stated, "Take the medications".

On at 8:44 am she stated , "I signed the medications earlier. I know that I cannot do that."

On at 8:53 am observed the medication pass for Resident # 4 by Staff C for Resident #2. Staff C came with a container with the medications together already inside, did not say the name of the medications and the medication observation record (MOR) was already signed.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview the facility failed to ensure that staff that assist the residents with self-administration of medications signed the medication observation records (MORs) after verifying that the residents swallowed the medications for 2 out of 7 sampled residents (Resident #1 and #4). The facility also failed to ensure that licensed staff that administer medications to Residents #3, #5 and # 6 signed the MORs after administering the medications to the residents.

Findings included:

During assistance with self-administration of medications on at 8:42 am observed Staff C assisting Resident # 2 with self-administration of medications.

On at 8:44 am Staff C stated , "I signed the medications earlier. I know that I cannot do that."

On at 8:53 am observed the medication pass for Resident # 4 by Staff C and the MORs were already signed.

Review of the MOR for Residents # 3, # 5 and # 6 revealed that it had not been signed since .

On Staff C stated at 9:07 am, "I got the medications ready because the nurse that gives them the medications is always in a hurry."

On the Registered Nurse arrived at 9:00 am to administer the medications to all the hospice residents. She stated that she comes twice a day every day and that she lives close to the facility and

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that she knows that she has to sign the MOR but she was in a hurry.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview the facility failed to keep medicines locked at all times.

Findings included:

During tour of the facility on at 7:59 am observed that the medication closet was located inside another closet that was sub-divided; there were 2 doors and both of them were unlocked. Also observed that there were three containers with medications inside with the names of the three residents under hospice services.

on at 8:00 am Staff C stated, "the other door was locked. The medications are ready because the nurse that comes to give the medications is always in a hurry, I know that I am not supposed to do that."

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview the facility failed to ensure that staff receive in-service training within 30 days of hire that covers the following training: Resident behavior and needs, providing assistance with activities of daily living, emergency procedures, reporting major or adverse incidents, resident rights and recognizing and reporting , neglect and , for 1 out of 6 sampled staff (Staff D).

Findings included:

Personnel record review of Staff D file revealed that she was hired to work on . The facility did not have any documentation that Staff D received the following training resident behavior and needs, providing assistance with activities of daily living, emergency procedures, reporting major or adverse incidents, resident rights and recognizing and reporting , neglect and .

The administrator stated on at 1:10 pm that Staff D took the training but he did not know what happened.

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Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview the facility failed to ensure that direct care staff receive at least 1 hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment for 1 out of 6 sampled staff(Staff D).

Findings included:

Personnel record review of Staff D's file revealed that she was hired on . Record review revealed that Staff D did not have the training documentation.

The administrator stated on at 1:10 pm that Staff D took the training but he did not know what happened.

Class III

0127 - Fiscal - Liability Insurance - 429.275 (3) FS; 58A-5.021(4) FAC

Based on record review and interview the facility failed to maintain liability insurance coverage in force at all times.

Findings included:

Review of the liability insurance revealed that it expired on .

On at 10:05 am the administrator stated, "We already made the arrangements to renew it. They have to send it to me."

On at 11:05 am he received a copy of the application to renew the liability insurance dated .

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observation, record review, and interview the facility failed to keep an up-to-date admission / discharge log.

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Findings included:

During tour of the facility on at 7:52 am Resident #1 was observed sleeping in bed with half bed rail up.

Record review of Resident # 1 revealed that he had a contract signed on .

Review of the admission / discharge log revealed that Resident # 1's name was not listed.

On at 8:27 am Resident # 1' wife stated on the phone, "He has been living there since Saturday; he is staying there."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney (POA) for 3 out of 7 sampled residents (Resident #1, #3 and #5).

Findings included:

Review of Resident #1's record revealed that the contract was signed by his wife on . There was no paperwork appointing the resident's wife as the responsible party in the facility.

On at 10:12 am the administrator stated, "Resident #1's wife is making all the arrangements to become his POA."

Record review of Resident # 3 revealed that her contract had been signed by her son.

On at 2:20 pm the administrator stated that her son has to bring the POA paperwork.

Record review of Resident # 5 revealed that her contract had been signed by her daughter and there was no copy of the POA in the record.

On at 2:27 pm the administrator stated that he will let Resident # 5's daughter know that she has to bring the papers for that appointment.

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interview the facility exceeded its operating license by providing assisted living services to a total of seven residents while being licensed for six beds.

Findings included:

During tour of the facility on at 7:55 am observed Resident #1 sleeping in bed in #.

On at 7:55 am Staff C stated, "Resident #1 practically does not live here because he goes to a program all day; he just stayed here last night."

On at 7:58 am during tour of the facility Staff C stated that # was occupied by Residents #5 and #7, but that Resident #7 had been admitted to the hospital the day before ( ) in the afternoon and she did not know if she was coming back to the facility.

On at 8:27 am Resident # 1's wife stated on the phone, "He has been living there since Saturday; he is staying there."

Review of the records revealed that there was a resident record for Resident #1 with the contract signed by his wife on ; there was also a bin full of medications with the resident's name and the medication observation record started to be signed since at night.

During the exit conference on at 3:30 pm; the administrator stated that he was not taking Resident #7 back from the hospital because she was in a really bad shape.

Unclassified